FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HEALTH HISTORY FORM

1. Are you currently taking any medication? yes (no)
   If so, what? _____

2. Are you allergic to or have you had a reaction to any food, materials, medications or drug? yes (no)
   If so, what? _____

3. Have you been under the care of a physician during the past two years? If so, why? _____ (yes) no

4. Have you been hospitalized in the past two years? yes (no)
   If so, why? _____

5. Do you have or have you ever had a heart murmur or been treated for a heart condition? yes (no)

6. Do your ankles ever swell during the day? yes (no)

7. Have you ever been treated for a tumor or growth? yes (no)

8. Have you ever had abnormal bleeding? yes (no)

9. Have you ever had serious difficulty with any dental treatment? yes (no)

10. Have you ever had clicking, popping, or pain in your jaw-joint? (yes) no

Circle any of the following that you have had:

Congenital heart defects	Heart murmur
Heart attack or heart problems	Angina
Stroke	High Blood pressure
Rheumatic Fever	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia (blood problems)	Diabetes
Thyroid problems	AIDS or HIV infection
Chronic bronchitis	Emphysema
Venereal disease (syphilis, gonorrhea)	Tuberculosis (TB)
Arthritis	Psychiatric treatment
Artificial heart valve	Artificial joint
Hepatitis	

Do you currently use tobacco (cigarettes, chewing tobacco, snuff)? yes (no)

Do you have any disease, condition, or problem not listed?
WOMEN ONLY: Are you pregnant?

Name: Darryl BAKER Reg No. 19613-039

Signature: Darryl Baker

Institution: FSL Elkton Date: 02-02-05

FEDERAL BUREAU OF PRISONS

HISTORIA CLINICA DE ODONTOLOGIA Y MEDICA

1. Que medicinas esta tomando actualmente? Si No
   Si es si, el nombre _____

2. A que comida, materiales, medicinas es usted alergico? Si No
   Si es si, el nombre _____

3. Tuvo alguna enfermedad durante los ultimos dos anos que requirio ver un doctor? Si No
   Si es si, por que? _____

4. Ha estado usted en el hospital durante los ultimos dos anos? Si es si, por que? Si No
   _____

5. Tiene usted o ha tenido historial de un soplo en el corazon o ha sido tratado por alguna otra condicion cardiaca? Si No

6. Se le hinchan los pies? Si No

7. Tiene cancer? Desde cuando? _____ Si No

8. Sangra usted con exceso? Si No

9. Ha tenido problemas con algun tratamiento dental? Si No

10. Ha tenido usted alguna vez tembiores, dislocaciones o dolores en su mandibula? Si No

Que enfermedades o sintomas tiene? De reconocerlos una marca:

Defectos del corazon	Soplo cardiaco
Ataque del corazon	Angina
Apoplejia o derrame cerebral	Presion alta
Fiebre reumatica	Marcapasos
Asma o fatiga	Convulsiones
Anemia (problemas de sangre)	Diabetes
Proplemas de tiroies	SIDA o infeccion de HIV
Bronquitis	Enfisema
Enfermedad venerea (gonorrea/sifilis)	Tuberculosis
Artritis	Desordenes psiquiatricos
Valvulas artificiales	Coyunturas artificiales
Hepatitis (problemas del higado)	

Usa usted frecuentemente tabaco (cigarrillos, mascar, rape)? Si No

Tiene otras enfermedades que no esten en esta lista? Si No

LAS MUJERES: Esta usted embarazada o encinta? Si No

Firma: _____ Fecha: _____

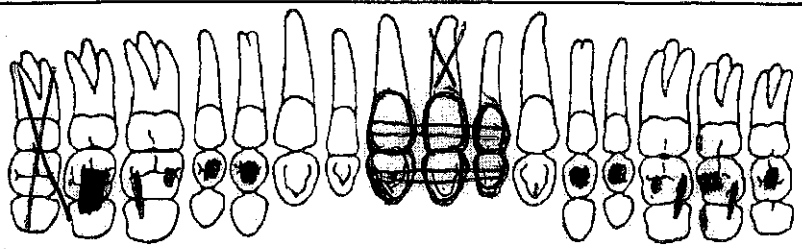
Nombre _____ Numero _____

FSL Elkton

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

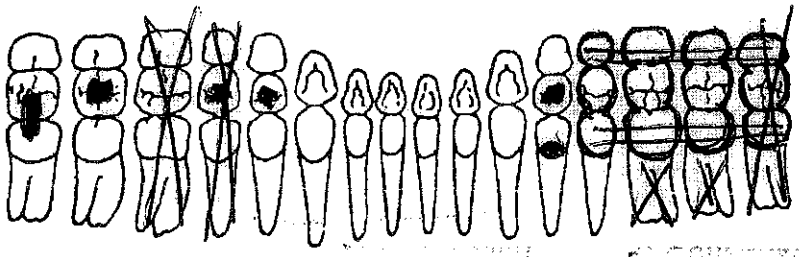
6-3-04

Examination: ☐ Screening ☒ Comprehensive ☐ Periodic



RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

enter 17/S crown



Occlusion: Class I

Oral Hygiene: Good (Fair) Poor

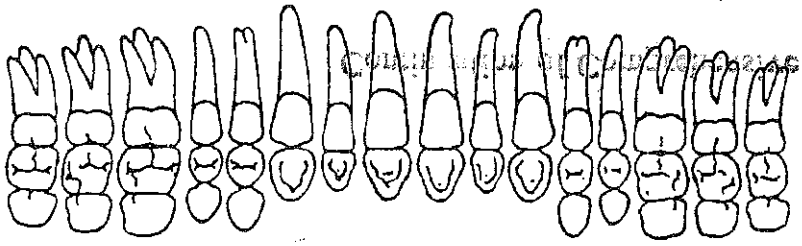
CPITN: 3 | 2 | 3 — 0 | 0 | 0 / 3 | 2 | 3 — 0 | 0 | 0 — 6-3-04 re eval

Head & Neck/Soft Tissue: SJWNL

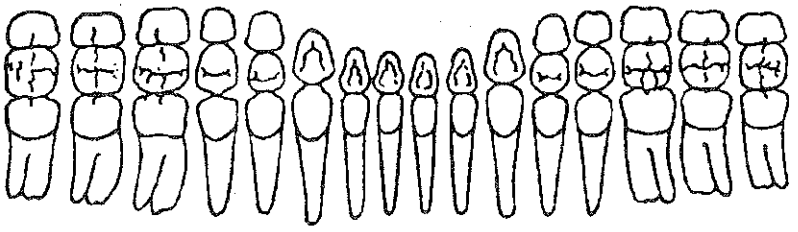
Additional Findings: B. lat. clicking
- 3 unit bridge 8,9,10
- 4 unit bridge 17-20

D: ___
M: ___
F: ___

Treatment Completed



RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Recommended Treatment Plan

☒ Radiographs 6-3-04 gs
VBWs ord

☒ Dental Prophylaxis
☒ Oral Hygiene Instruction 5-21-04 gs

☒ Periodontal Evaluation (0) I II III
6-3-04 gingivitis

☐ Oral Surgical Procedures

☐ Endodontic

☒ Restorative 21-16 6-22-04

☐ Prosthodontic Evaluation

Patient Name: Baker, Darryl Number: 19623-039 Sex: (M) F Age: 41
6-30-62

Dentist Signature: W. K. Collins, DDS Date: 5-21-04
W. K. Collins, DDS
CDO
FCI McKean

FCI McKean

000150

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
5-21-04		SOA: Routine Care pt
1130hrs		P: Comp. HH, soft tissue exam, assessment.
		Pt state No Hx of Dental cleanings. Presents
		w/ slight → Mod calc + stain. Ultrasonic
		Q1-4. Selective hand scale, polish, OHI
		on bridge flossers. 2 packets given. NEXT:
		Comp exam + BWx4 —— Johanna J Schroll RDH
		J.L. Schroll, RDH
		FCI McKean
		[signature]
		W. K. Collins, DDS
		CDO
		FCI McKean
06-03-04		**Continuation of Comprehensive Exam**
1215hrs		**1. Charting** **3. Oral Cancer Exam**
		2. Oral Exam **4. Consultation**
		Pt to watch callouts for tx [signature] D.D.S.
		G. F. Greer D.D.S.
		[signature]
		William K. Collins D.D.S.
6-22-04		SOA: Rt. care Pt.
1130 hrs.		Med. Hist Rvd NKDA
		P: Lidocaine 1:100,000 2% epi x1
		cl V resin #21
		Pt. completed [signature] D.D.S.
		G. F. Greer D.D.S.
		[signature]

William K. Collins, D.D.S.
CDO
FCI McKean

Language template provided in Spanish ____, or _____.

1. Are your currently taking any medication? If so, what? _____	____ YES	✓ NO
2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? _____	____ YES	✓ NO
3. Have you been under the care of a physician during the past two years? If so, why? _____	____ YES	✓ NO
4. Have you been hospitalized in the past two years? If so, why? _____	____ YES	✓ NO
5. Do you have or have you ever had a heart murmur or been treated for a heart condition?	____ YES	✓ NO
6. Have you ever been treated for a tumor, growth, or cancer?	____ YES	✓ NO
7. Have you ever had excessive or prolonged bleeding as a result of a medical condition or medication (ex. Hemophilia or blood thinners)?	____ YES	✓ NO
8. Do you have a latex allergy?	____ YES	✓ NO
9. Do you currently use tobacco products?	____ YES	✓ NO
10. WOMEN ONLY: Are you pregnant?	____ YES	____ NO

Check any of the following that you have had:

____ Congenital heart defects
____ Heart attack or heart problems
____ Stroke
____ Rheumatic fever
____ Mitral Valve Prolapse
____ Anemia (blood problems)
____ Thyroid problems
____ Chronic bronchitis
____ STD (syphilis, gonorrhea, herpes)
____ Angio edema
____ Arthritis
____ Artificial heart valve
____ Hepatitis (☐A ☐B ☐C)
____ Any type of transplant
____ Steroid treatment
____ Sickle Cell Anemia
____ Angina
____ High blood pressure
____ Heart pacemaker
____ Glucose - 6-phosphate dehydrogenase deficiency
____ Epilepsy or seizures
____ Diabetes
____ AIDS or HIV infection
____ Emphysema
____ Tuberculosis (TB)
____ Psychiatric treatment
____ Artificial joint
____ Radiation therapy
____ Asthma

Do you have any disease, condition, or problem not listed? _____

Check any of the following that you have had or applies to you:

____ Sensitive teeth
____ Bleeding gums
____ Food impaction
____ Pain around ear
____ Tooth ache
____ Wear partial dentures
____ Unusual sounds while eating
____ Snoring
____ Blisters on lips or mouth
____ Clenching or grinding
____ Swelling or lumps in mouth/throat
____ Burning tongue
____ Bad breath
____ Decayed teeth
____ Loose teeth
____ Wear dentures

Printed Name: DARRYL BAKER	Signature: Darryl Baker
Reg. No.: #19613-039	Institution: F.C.I. Mckean
Date: 5-21-04	Updated:

(This form may be replicated via WP)

CLINICAL RECORD	DENTAL TREATMENT RECORD (Continuation)	
DATE	DIAGNOSIS - TREATMENT - REMARKS	SIGNATURE
05/12/2000 1030hrs	P: A permanent restoration is placed during the routine care/Maintenance phase, not at sick call. Patient instructed to come back on 12/16/2000 at 0730hrs and a Ketac Silver restoration will be placed in #31.	W.K. Collins, DDS Chief Dental
03/05/03 0840hrs	S: "My filling came out." (Patient points to #31) (PC#:0) O: Med Hx Rev'd: NKDA #31, Patient d/c missing restoration A: #31, missing restoration P: Patient to be scheduled for restorative procedure.	William K. Collins, D.D.S. CDO FCI McKean

(Continued On Reverse Side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

Baker, Darryl

FCI McKean

REGISTER NO. 17613-039

WARD NO.

DENTAL TREATMENT RECORD
HRSA-237 (4/95)

DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS - TREATMENT - REMARKS	SIGNATURE
04/04/03 0930hrs	P: Patient in 5HU.	William K. Collins, D.D.S. CDO FCI McKean

F.C.I. McKEAN

Bradford, PA 16701

CLINICAL RECORD | **DENTAL TREATMENT RECORD (Continuation)**

DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATUR
1/4/96 1502	No Anes.; #31 (MO) - etch-bond-comp. "5; Lux Aw" 4J shade); Scheduled for Prophy.	CABANAS, D.M.D. CHIEF DENTAL OFFICER
11/16/98 1330	(S) Lost filly (O) #2 ☐ Oh filly - + groove missing filly (A) Rev. pulpitis (P) Placed True Vitality.	WG. STERBA DDS
11/17/98 0930	(S) Lost filly (O) #2 ☐ missing OC aspect. Pt states filly was not!! (A) Rev. Pulpitis (P) TPH.	WG. STERBA DDS
04/28/2000 0920 hrs	S: "I lost a filling out of this tooth" O: Patient points to #62 DENTAL Occlusal restoration partially fractured out Dental caries present A: #62, Fractured restoration 2° chronic caries	over

(Continued On Reverse Side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Baker, Darryl
19613-039
FCI McKean

REGISTER NO. | WARD NO.

DENTAL TREATMEN

HSA-237 (6-74)

000155

cntd from other side

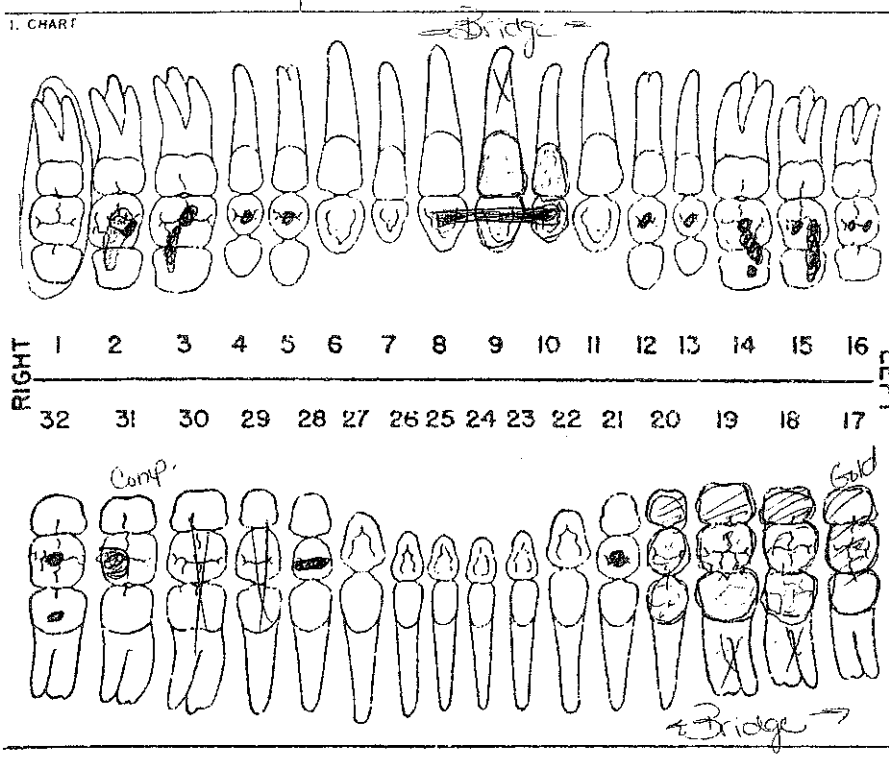
DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
04/28/2000 0940hrs	P: Lidocaine 2% c 1:100,000 epinephrine x3, caries removal, part of current restoration allowed to remain; Occlusal restoration placed in #02 using Ketac Silver; Occlusal adjustment. Patient instructed to submit a "cop-out" requesting an examination and a prophylaxis.	W.K. Collins, DDS Chief Dental
05/12/2000 1030hrs	S: "My tooth has been hurting me when I chew on it." O: #31, worn down DO resin restoration Med Hx: Reviewed Pax: Root canal therapy has been performed on tooth Apices of roots appear WNL percussion: Patient may be attempting to abuse sick call. A: No pathology observed other than worn fillings P: Explained to patient that present restoration is satisfactory	W.K. Collins, DDS Chief Dental

DENTAL

CLINICAL RECORD | **DENTAL**

1. CHART



2. ROENTGENOGRAMS
☐ PERIAPICAL ☐ BITE WINGS ☐ OTHER

3. PERIODONTOCLASIA
☐ INCIPIENT ☐ MODERATE ☐ SEVERE
☐ LOCAL ☐ GENERAL

4. CALCULUS
☐ SLIGHT ☐ MODERATE ☐ HEAVY

5. GINGIVAL PATHOLOGY
☐ GINGIVITIS ☐ VINCENT'S INFECTION
☐ STOMATITIS (*Specify*)

6. DENTURE INDICATED (*Include dentures needed after indicated extractions*)
☐ FULL UPPER ☐ FULL LOWER
☐ PARTIAL UPPER ☐ PARTIAL LOWER ☐ REPAIR

7. ABNORMALITIES OF OCCLUSION, ANGLES CLASSIFICATION
☐ I ☐ II ☐ III ☐ NORMAL

8. DENTAL CLASSIFICATION | 9. TYPE OF EXAMINATION

10. ADDITIONAL FINDINGS

D - O
M - S
F - F

CHIEF DENTAL OFFICER

11. RECOMMENDATIONS

Typhan
1.) Prophy, Bws
2.)

12. APPROXIMATE TIME REQUIRED FOR DENTAL TREATMENT

13. DATE 11/8/95

14. SIGNATURE OF DENTIST R.A. CABANAS 5/DMD

R. CABANAS, D.M.D.
CHIEF DENTAL OFFICER

15. GRADE, RATING, OR POSITION	16. TYPE OF BENEFICIARY	17. SEX ☐M ☐F	18. RACE	19. AGE	20. SERVICE ☐INPATIENT ☐OUTPATIENT ☐OTHER

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

Baker, Darryl
19613-039
FCI McKean

22. IDENTIFICATION NO.	23. REGISTER NO.	24. WARD NO.

DENTAL

Standard Form 521 (Rev.)
521-108

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

000157

INFORMATION FOR DENTAL SERVICE *(To be filled in by referring agency)*

26. PRINCIPAL MEDICAL DIAGNOSIS

27. CHECK HERE IF HOSPITALIZED FOR DENTAL TREATMENT ONLY ☐

28. PATIENT REFERRED FOR

29. REMARKS

30. APPROXIMATE PERIOD OF HOSPITALIZATION	31. DATE	32. SIGNATURE OF PHYSICIAN
		R. CABANAS, D.M.D. CHIEF DENTAL OFFICER

AUTHORIZATION

33. DENTAL TREATMENT AUTHORIZED

34. DATE	35. SIGNATURE OF AUTHORIZING DENTIST

36. TREATMENT RECORD

DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
CO 1130 11/8/95	A° exam, H Hx reviewed, Sc, CO & waiting	R.A. CABAÑAS DMD
	list explained STUNK OHI	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
1/29/96/1230	Comprehensive exam. – Same charting	
	as 11/8/95 except for Fx. of OL	
	composite #2; 2% Lido c̄ 1:10⁻⁵ epi	
	x 1.8 cc ("Schein"); #2 (OL) – Varn-	
	AMAL ("Unison"). Needs /P	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
	to maintain extent space #29-30 & to	R.A. CABAÑAS
	prevent supraeruption of #4.	DMD
	Scheduled for impressions for /P.	R
	(Permanent restoration done on Sick Call	
	today due to low pt load today)	R
5/2/96/0935	Lower alginate impr made. RA	R.A. CABAÑAS DMD
"	Schedule for Op. #31 (restore MO crack) R	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
5/6/96/1556	del /P. Instructions in use + care given. R	R.A. CABAÑAS DMD R. CABANAS, D.M.D. CHIEF DENTAL OFFICER

*U.S. Government Printing Office: 1991 — 281-782/40101

000158

F.C.I. McKEAN

Bradford, PA 16701

CLINICAL RECORD	DENTAL TREATMENT RECORD (Continuation)	
DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
7/18/96/1606	Rescheduled for Op., Not seen today due to unscheduled dept. meeting.	R.A CABANAS DMD R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
8/26/96/1555	No show for Call Out 1430, Rec	R.A. CABANAS D.M.D. R. CABANAS, D.M.D. CHIEF DENTAL OFFICER

DENTAL

(Continued On Reverse Side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical unit)

Baker, Darryl
19613-039
FCI McKean

REGISTER NO.

WARD NO.

DENTAL TREATMENT RECORD

HSA-237 (6-74)

000159

A-237 (6-74)
(reverse)

DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS -- TREATMENT -- REMARKS	SIGNATURE

U.S. Bureau of Prisons
Dental/Medical History Form

1. Are you presently taking any medication? If so, what?_____	Yes	(No)
2. Are you allergic to or have you had a reaction to any medication or drug? If so, what?_____	Yes	(No)
3. Have you been under the care of a physician during the past two years? If so, why?_____	Yes	(No)
4. Have you been hospitalized in the past two years? If so, why?_____	Yes	(No)
5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired?	Yes	(No)
6. Do your ankles ever swell during the day?	Yes	(No)
7. Have you ever been treated for a tumor or growth?	Yes	(No)
8. Have you ever had abnormal bleeding?	Yes	(No)
9. Have you had any serious difficulty with any previous dental treatment?	Yes	(No)

Circle any of the following that you have or have had:

Congenital heart defects	Heart murmur
Heart attack or heart trouble	Angina
Rheumatic Fever	High blood pressure
Stroke	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia(blood problems)	Diabetes
Hepatitis	AIDS or HIV infection
Thyroid problems	Emphysema
Chronic bronchitis	Tuberculosis (TB)
Venereal disease (syphilis, gonorrhea)	Psychiatric treatment
Arthritis	Artificial Joint Prosthesis
Artificial Heart Valve	

Do you have any disease, condition, or problem not listed?	Yes	(No)
WOMEN ONLY: Are you pregnant?	Yes	No

Name Darryl Baker Reg. No. 19613-039

Institution FCI McKean Date 11-8-95

000161

U.S. Bureau of Prisons
Historia Clinica de Odontologia y Medica

1.	¿Que medicinas estra tomando actualmente ? Si es si el nombre_____	SI	NO
2.	¿A que medicinas es usted ALERGICO ? Si es si el nombre_____	SI	NO
3.	¿Tuvo alguna enfermedad durante los ultmos dos anos que requero ver un doctor ? Si es si, por que ?_____	SI	NO
4.	¿Ha estado usted en el Hospital durante los ultimos dos anos ? Si es si, por que ? _____	SI	NO
5.	¿Tiene alguna dificultad para respirar o dolor en el pecho o se siente agotado cuando cuando sube las escaleras ?	SI	NO
6.	¿Se le hinchan los pies ?	SI	NO
7.	¿Tiene cancer ? ¿Desde cuando ?_____	SI	NO
8.	¿Sangra usted con exceso ?	SI	NO
9.	¿Ha tenido problemas con los dientes ?	SI	NO

Que enfermedades o sintomas tiene, que sepa ponga una marka:

Defectos del corazon	Soplo cardiaco
Altaque del corazon	Angina
Fiebre Reumatica	Presion alta
Apoplejia o Derame Cerebral	Marcapasos
Asma o Fatiga	Convulsiones
Anemia (problemas de sangre)	Diabetes
Hepatitis	SIDA o HIV infection
Problemas de tiroides	Enfisema
Bronquitis	Tuberculosis
Enfermedad Venerea (Gonorrea/Sifilis)	Desordenes psiquiatrias
Artritis	Coyunturas artificiales
Valvulas artificiales	

¿Tiene otras enfermedades que no estra en estra lista ? SI NO

Pregunta para las mujeres.
¿Esta usted embarazda o encinta ? SI NO

Nombre_____ Numero_____

Institution_____ Fetcha_____

FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HISTORY FORMS

1. Are you presantly taking any medication? Yes (No)
   If so, what?_____

2. Are you allergic to or have you had a reaction to any medication or drugs? If so, what?_____ Yes (No)

3. Have you been under the care of a physician during the past two years? If so, why?_____ Yes (No)

4. Have you been hospitalized in the past two years? Yes (No)
   If so, why?_____

5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired? Yes (No)

6. Do your ankles ever swell during the day? Yes (No)

7. Have you ever been treated for a tumor or growth? Yes (No)

8. Have you ever had abnormal bleeding? Yes (No)

9. Have you had any serious difficulty with any previous dental treatment? Yes (No)

Circle any of the following that you have or have had:

Congenital heart defects	Heart murmer
Heart attack or heart trouble	Angina
Rheumatic Fever	High blood pressure
Stroke	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia (blood problems)	Diabetes
Hepatitis	AIDS or HIV infection
Thyroid problems	Emphysema
Chronic bronchitis	Tuberculosis (TB)
Venereal disease (syphilis, gonorrhea)	Psychiatric treatment
Arthritis	Artificial prosthesis
Artificial heart valve	

Do you have any disease, condition, or problem not listed? Yes (No)

Name Darryl Baker Reg. No. 19613-039

Institution FDC Milan Date 10-4-95

000163

U.S. BUREAU OF PRISONS
HISTORIA CLINICA DE CONTOLOGIA y MEDICA

1. Que medicinas estra tomando actualmente? SI ----- NO -----
   Si es si el nombre _____
2. A que medicinas es usted ALERGICO? SI ----- NO -----
   Si es si el nombre _____
3. Tuvo alguna enfermedad duranto los ultmos dos anos que requero ver un doctor? SI ----- NO -----
   Si es si, por que? _____
4. Ha estado usted en el Hospital duranto los ultimos dos anos? Si es si, por quo? SI ----- NO -----
   _____
5. Tiene alguna dificultad para respirar o dolor en el pecho o se siento agotado cuando cuando sube las escaleras? _____ SI ----- NO -----
6. Se le hinchan les pies? _____ SI ----- NO -----
7. Tiene cancer? Desde cuanso? _____ SI ----- NO -----
8. Sangra usted con exceso? _____ SI ----- NO -----
9. Ha tenido problems con los dientes? SI ----- NO -----

Que enfermedades o sintomas tiene, que sepa ponga una marka:

Defectos del corazon	Soplo cardiaco
Altaque del corazon	Angina
Fiebre Reumatica	Presion alta
Apoplejia o Derame Cerebral	Marcapasos
Asma o Fatiga	Convulsiones
Anemia (problems de sangre)	Diabetos
Hepatitis	SIDA o HIV infection
Problemas de tiroides	Enfisoma
Bronquitis	Tuberculosis
Enfermedad Venerea (Gonorrea/Sifilis)	Desordenes psiquiatrias
Artritis	Coyunturas artificiales
Valvulas artificiales	

Tiene otras enfermedades; que no estan en esta lista? SI ----- NO -----

Nombre _____ Numero _____

Institution _____ Fecha _____

FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HISTORY FORMS

1. Are you presantly taking any medication? Yes (No)
   If so, what?_____

2. Are you allergic to or have you had a reaction to any medication or drugs? If so, what?_____ Yes (No)

3. Have you been under the care of a physician during the past two years? If so, why?_____ Yes (No)

4. Have you been hospitalized in the past two years? Yes (No)
   If so, why?_____

5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired? Yes (No)

6. Do your ankles ever swell during the day? Yes (No)

7. Have you ever been treated for a tumor or growth? Yes (No)

8. Have you ever had abnormal bleeding? Yes (No)

9. Have you had any serious difficulty with any previous dental treatment? Yes (No)

Circle any of the following that you have or have had:

Congenital heart defects
Heart attack or heart trouble
Rheumatic Fever
Stroke
Asthma
Anemia (blood problems)
Hepatitis
Thyroid problems
Chronic bronchitis
Venereal disease (syphilis, gonorrhea)
Arthritis
Artificial heart valve
Heart murmer
Angina
High blood pressure
Heart pacemaker
Epilepsy or seizures
Diabetes
AIDS or HIV infection
Emphysema
Tuberculosis (TB)
Psychiatric treatment
Artificial prosthesis

Do you have any disease, condition, or problem not listed? Yes No

Name Daryl Baker Reg. No. 19613-039

Institution F.D.C. MILAN Date 6-8-95

000165

U.S. BUREAU OF PRISONS
HISTORIA CLINICA DE CONTOLOGIA y MEDICA

1. Que medicinas estra tomando actualmente? SI ----- NO -----
   Si es si el nombre _____
2. A que medicinas es usted ALERGICO? SI ----- NO -----
   Si es si el nombre _____
3. Tuvo alguna enfermedad duranto los ultmos dos anos que requero ver un doctor? SI ---- NO ----
   Si es si, por que? _____
4. Ha estado usted en el Hospital duranto los ultimos dos anos? Si es si, por quo? SI ---- NO -----
   _____
5. Tiene alguna dificultad para respirar o dolor en el pecho o se siento agotado cuando cuando sube las escaleras? _____ SI ----- NO -----
6. Se le hinchan les pies? _____ SI ----- NO -----
7. Tiene cancer? Desde cuanso? _____ SI ----- NO -----
8. Sangra usted con exceso? _____ SI ----- NO -----
9. Ha tenido problems con los dientes? SI ----- NO -----

Que enfermedades o sintomas tiene, que sepa ponga una marka:

Defectos del corazon	Soplo cardiaco
Altaque del corazon	Angina
Fiebre Reumatica	Presion alta
Apoplejia o Derame Cerebral	Marcapasos
Asma o Fatiga	Convulsiones
Anemia (problems de sangre)	Diabetos
Hepatitis	SIDA o HIV infection
Problemas de tiroides	Enfisoma
Bronquitis	Tuberculosis
Enfermedad Venerea (Gonorrea/Sifilis)	Desordenes psiquiatrias
Artritis	Coyunturas artificiales
Valvulas artificiales	

Tiene otras enfermedades; que no estan en esta lista? SI ----- NO -----

---

Nombre _____ Numero _____

Institution _____ Fecha _____

000166

FED ORRECTIONAL INSTITUTIO OSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: DATE: 8/9/99.
INMATE'S NAME: Baker Danny L DETAIL: REG. NO. 19615-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

X IDLE: Reason Medical THRU 12 MIDNIGHT 8/10 19 99
( ) CONVALESCENCE: List any restricted activity for medical reasons. THRU 12 MIDNIGHT 19
( ) RESTRICTED DUTY: Specify exact restriction and reason. THRU 12 MIDNIGHT 19
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

DLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious ser all, visits and call outs. No recreation activity.
ONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excus nd may not participate in any recreational activities outside the unit.
ESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific dat
OTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
ULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDE ORRECTIONAL INSTITUTIC HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: A A DATE: 2/25/99
INMATE'S NAME: Baker DETAIL: medical REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason Medical THRU 12 MIDNIGHT 2/26 19 99
( ) CONVALESCENCE: List any restricted activity for medical reasons. THRU 12 MIDNIGHT 19
( ) RESTRICTED DUTY: Specify exact restriction and reason. THRU 12 MIDNIGHT 19
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

000167

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefilte.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL (RRECTIONAL INSTITUTION OSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED Baker, D UNIT: 1A DATE: 5/19/98
INMATE'S NAME: _____ DETAIL: Unicor REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason _____ THRU 12 MIDNIGHT 5/19 19 98
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) TOTALLY DISABLED: Rest
( ) FULL DUTY: No Sports/Rec x 1wk

T. Montgomery, MLP
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL \ RRECTIONAL INSTITUTION OSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: _____ DATE: 1/23/98
INMATE'S NAME: Baker, Darryl DETAIL: _____ REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason _____ THRU 12 MIDNIGHT 1/24 19 98
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Physician or Physician Assistant

000168

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: _____ DATE: 11/25/97
INMATE'S NAME: Baker Darryl DETAIL: _____ REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Medical THRU 12 MIDNIGHT 11/25 1997
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

W. Hall, M.D.
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 12-30-96
INMATE'S NAME: Baker, Darryl DETAIL: CMS REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Muscle Sprain THRU 12 MIDNIGHT 12-31, 1996
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

SHARONE A. WALTER
PHYSICIAN ASSISTANT
S. Walter P.A.
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

000169

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 12-26-96
INMATE'S NAME: Baker, Darryl DETAIL: CMS REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Muscle Sprain THRU 12 MIDNIGHT 12-27, 19 96
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ____
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ____
( ) TOTALLY DISABLED:
( ) FULL DUTY:

S. Walter P.A.
SHARONE A. WALTER PHYSICIAN ASSISTANT
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 5/21/96
INMATE'S NAME: Baker, Darryl DETAIL: Quarters REG. NO. _____

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions) 19613-039

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 5/21 19 96
(X) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ____
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ____
( ) TOTALLY DISABLED:
( ) FULL DUTY:

OWEN CONNELLY, FMG, PA
OWEN CONNELLY, FMG
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

000170

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 5-13-96
INMATE'S NAME: BARKER DARRYL DETAIL: UNICOR REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason _____ THRU 12 MIDNIGHT 5-14 1996
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19__
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19__
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Must not exercise for meals
Catheter Restriction x 2 months

A. F GUNTHER M D
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 1/30/96
INMATE'S NAME: Barker Darryl DETAIL: Welding Shop REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 1/30 19 96
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19__
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19__
( ) TOTALLY DISABLED:
( ) FULL DUTY:

No gym or exercise 2 weeks

J. GOMEZ, PMG. PA
Physician or Physician Assistant

000171

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED Baker, Darryl UNIT: 1A DATE: 11/22/95
INMATE'S NAME: DETAIL: CMS REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 11/24 1995
(X) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

O. CONNELLY, FMG, PA
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

O: ALL CONCERNED Baker, Darryl UNIT: 1A DATE: 11/20/95
NMATE'S NAME: DETAIL: CMS REG. NO. 19613039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

IEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

) IDLE: Reason _____ THRU 12 MIDNIGHT 11/20 1995
) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
) TOTALLY DISABLED:
) FULL DUTY: No sports, no weight lifting at gym

GOMEZ, FMG, PA
Physician or Physician Assistant
GOMEZ, FMG

DEFINITIONS AND INSTRUCTIONS

DLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work
participate in any recreational activities outside the unit.
work limitation and time period, either specific date or indefiite.

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
Elk	Baker, Darryl	19613-039
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
SHU	SHU 130	8/11/05 ≅ 1230pm
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
FSC Visity Room		8/12/05 1730pm

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

"The restraints were excessively tight and my wrists hurt." "It hurt my ankles too."

unable to sign
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken _____ *Not Indicated* _____
X-Ray Results

c/o Soreness on b.lat wrists ø swelling, ø redness, full ROM of wrists distal circulation intact ø visible or palpable abnormalities. c/o b.lat ankle pain, ø swelly, ø redness, full ROM of ankles ø visible abnormalities noted.

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

Alt in health status

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Pt Ed tylenol or motrin PRN for Pain. flu c SHU

PA/sick call for further c/os

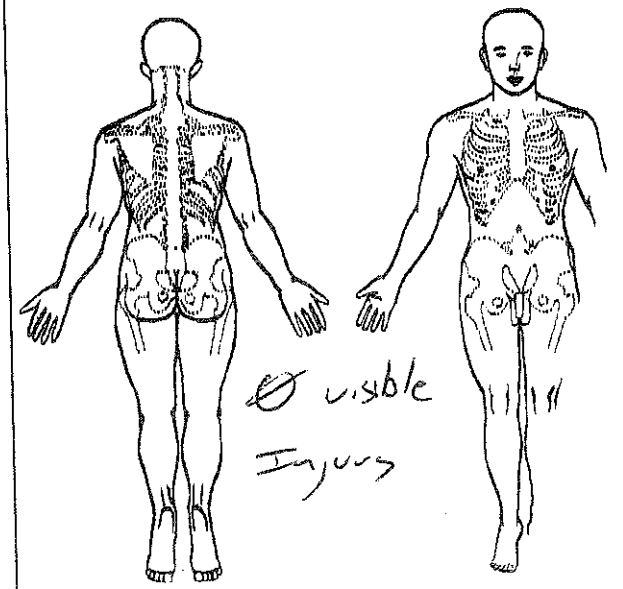
13. This Injury Required:

- ☐ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☒ d. Other (*explain*) Exam

MICHELE J. KELLER, D.O.
CLINICAL DIRECTOR

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

Cmc Connell RN
Signature of Physician or Physician Assistant



000173

Self Carboned Form – If ballpoint pen is used, **PRESS HARD**

Original – Medical File
Canary – Safety
Pink – Work Supervisor (Work related only)

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	BAKER, DARRYL	19613-039
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Unicor	A1A	2/27/04 2000hrs
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Housing A1A Cell #129		2/29/04 0950hrs

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

4'1"/0 PP 0" c/o (1.) LT. Face & Eye Pain 2° assaulted by 2-Inm's c/ ∅ LOC; Also c/o (2.) Minor Pain Swelling & Abrasions of RT Chest & Back, RUE, B/L. HANDS. (3.) Reports Epistaxis - 1ST 24hrs S/P ∅ Denies: D/SOB, HL, VISION LOSS, LOC

Darryl Baker
Signature of Patient

(4.) C/O Residual (L) Paresthesia of Face & Maxilla Dentition

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken _____ Not Indicated ✓

X-Ray Results

CAOx3, Mod Distress, Ambulatory, Flat Affect. HEAD ⇒ NC/AT; EARS ⇒ ∅ BLD, TMs INTACT ∅ FLD/BLD.; FACE ⇒ LT. mild Tender c Ecchymosis & Swelling & Step-off/Deformity; 5 fx intact c (+) Periorbital Ecchymosis/Edema, (+) Tender, & Step-off; NOSE ⇒ Neutral NT PYRAMID & TIP c mild Ecchymosis LT > RT, NOSE ⇒ (+) DNS - RT, B/L NT. MUCOSAL EDEMA LT > RT c DRIED ∅ FRESH BLD. LEFT ∅ VISIBLE Rupture; CHEST/BACK + UE's (See DIAGRAM.); NEURO ⇒ CN's II-XII Intact; PERRLA; LT. CONJUNCTIVITIS, EOMI

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

(1.) Periorbital Soft Tissue Trauma Ecchymosis/Edema ∅ FX (7.) Epistaxis ∅ FX.
(2.) LT. MAXILLA/ZYGOMA CONTUSION ∅ FX (4, 5.) Contusions, Sprain
(3.) ∅ CONTUSION (+) ABRASION (Superficial) (+) Superficial Abrasions
(6.)

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

(1.) Gentamycin 3cc Topical LT. Nose x 1 (+) Epistaxis Prophylaxis Instructions.
(2.) Snellen Eye Exam Acuity @ 20/25 Bilat
(3.) Educate Counsel re. Trauma c RTC-PRN
(4.) Understands

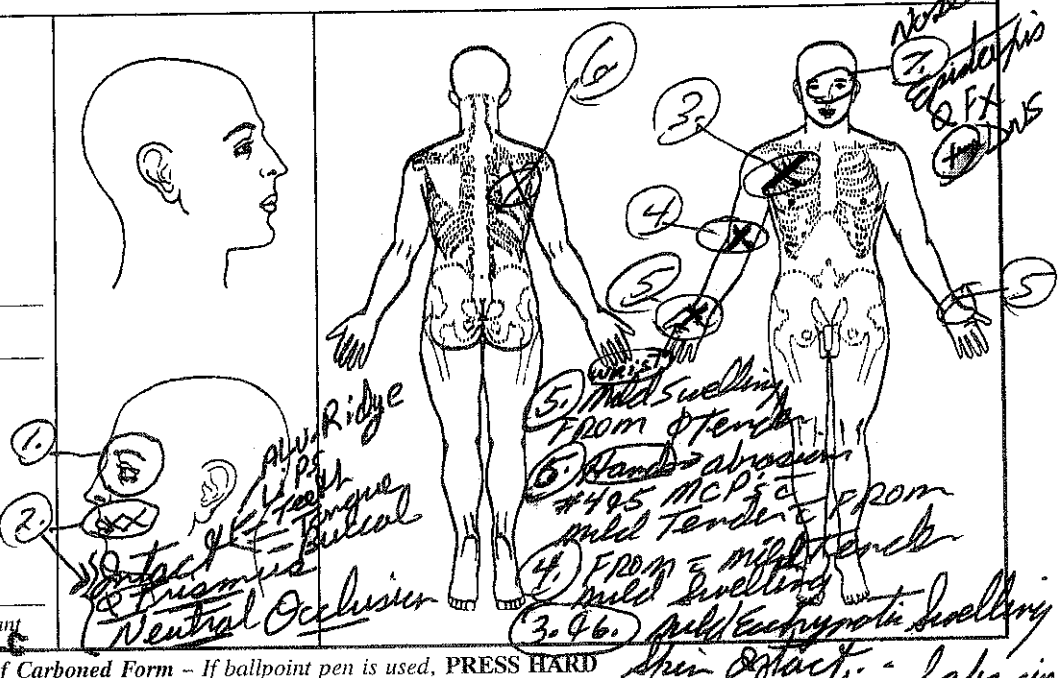
13. This Injury Required:

- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician



Robert E. Piotrowski, PA-C
FCI McKean
Signature of Physician or Physician Assistant

Self Carboned Form – If ballpoint pen is used, PRESS HARD

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)

Reviewed by D. Olson, MD

000174

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJU[illegible] SSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	Baker	19613-039
4. Injured's Duty Assignment	**5.** Housing Assignment	**6.** Date and Time of Injury
Rec. Orderly	AA	12-15-99 06:50
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8.** Date and Time Reported for Treatment
Rec Gym Floor		12-15-99 07:30

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

Saw IM Harris standing against wall when I walked in Main Gym area before incident happened.

x Darryl Baker
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

HEENT: WNL Neck: ⊖ findings

X-Rays Taken _____ *Not Indicated* ✓
X-Ray Results

Torso: ⊖ bruising or abrasions Ext: ⊖ bruising or abrasions

⊖ cuts.

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

No physical finding to R/o physical altercation

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

If any problems should arise F/u S/C

Im understands directions

13. This Injury Required:

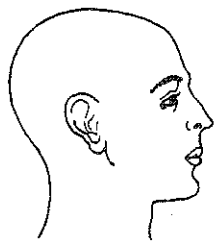
- ☒ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

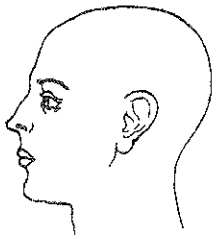
_____

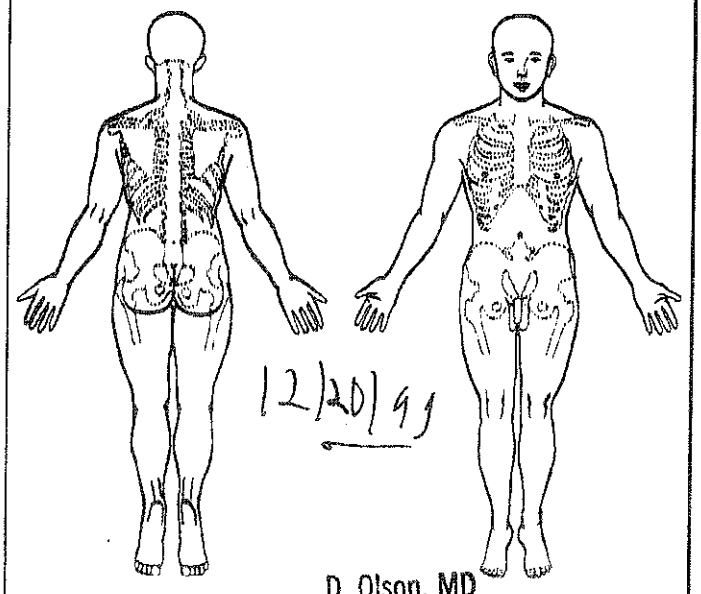
_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

Eric Kessel
Signature of Physician or Physician Assistant







12/20/99

D. Olson, MD
Clinical Director

Self Carboned Form – If ballpoint pen is used, PRESS HARD

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKEAN.	BAKER Darryl	19613-039
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Unicor.	1A.	2/25/99. 1200
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Rec Weight Room		2/25/99 1300

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

I went to Rec to Lift @ Lunchtime & Strained my lower back.

x Darryl Baker
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

↓ ROM & Int Flexion & (L) Lat.

X-Rays Taken _____ *Not Indicated* ✓

X-Ray Results

Flexion Also & (L) Leg Raise. + Facial Tenderness (R) Lumbar Paraspinals

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

LSSS

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Rest & Moist Heat. Understands

Motrin 800mg #21 TID x 1

Patient Educ -

C. Gelsick, R.Ph

13. This Injury Required:

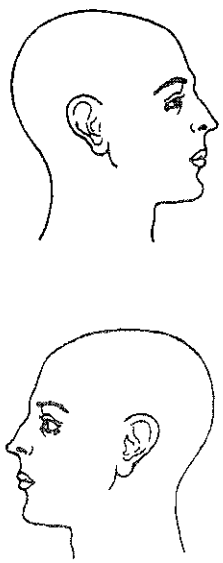
- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

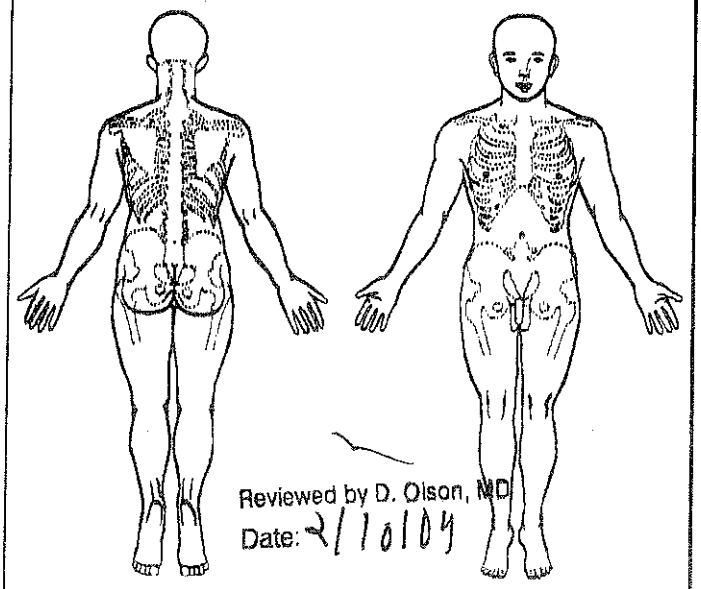
_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

Signature of Physician or Physician Assistant





Reviewed by D. Olson, MD
Date: 2/10/04

Self Carboned Form – If ballpoint pen is used, **PRESS HARD**

Medical File
Gu ty
USP Supervisor (*Work related only*)
ctional Supervisor

000176

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY SESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	Baker, Darryl	19613-039
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
CMS	1A	12-26-96 1445
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Gym		12-26-96 1830

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

Dead lifting 405 lbs. felt Something pull in my back.

Daryl Baker
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

pt. can bend forward ~45°, L ROM ~ 20° to right, tenderness palpation @ Supra Spinatous muscles in L-5 area, @ erythema or Swelling. DTR's @2, good Strength, NoV intact pain Straight leg raise both Sitting + laying, pain ~~addiction~~ @ leg

X-Rays Taken _____ *Not Indicated* X
X-Ray Results

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

Muscle Sprain

12. Plan: (*Medical Actions, Results, Treatment and Recommended Follow-up*)

PATIENT EDUCATION

1. ice, meds, rest
2. Motrin 800 mg. + PO TID, #21, no refill
3. idle 1 day
4. F/u PRN

PATIENT EDUCATION
Dosage
Special Instructions
~~Adverse Reaction~~
C. Gelsick, R.PH.

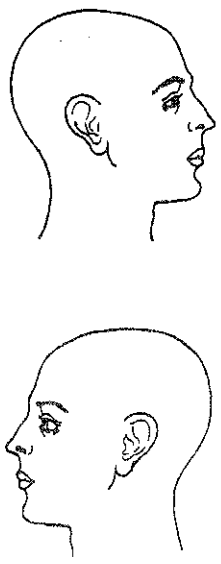
13. This Injury Required:

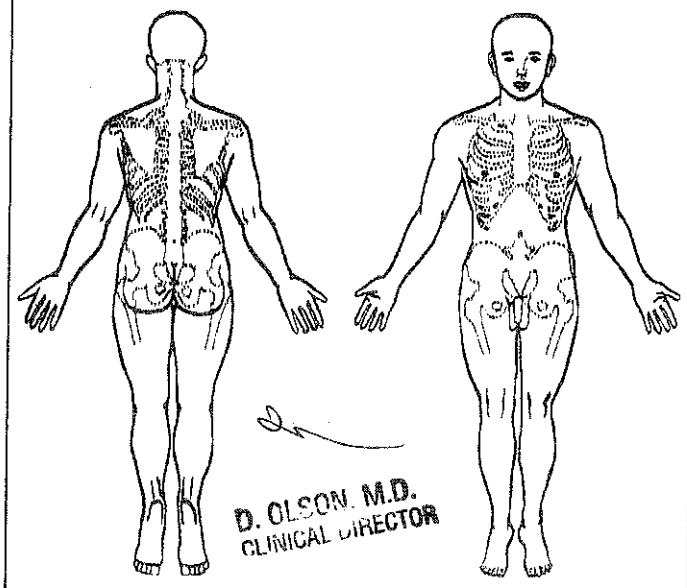
- ☐ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician





D. OLSON, M.D.
CLINICAL DIRECTOR

S. Walter P.A.
Signature of Physician or Physician Assistant
SHARONE A. WALTER
PHYSICIAN ASSISTANT

Self Carboned Form – If ballpoint pen is used, PRESS HARD

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

000177

MEDICAL DEPARTMENT
AUGUST 12, 2005

1) I AM HAVING EXCRUCIATING PAIN IN MY LEFT EYE AND NEED TO SEE A OPTICAL SPECIALIST.

2) I AM HAVING PAIN AS A RESULT OF SOME TIGHT RESTRAINTS ON MY WRIST AND SOME SWELLING.

3) I AM HAVING SOME SINUS PROBLEMS WITH MY ALLERGIES.

THANK YOU VERY MUCH

BY: INMATE BAKER
19613-039

CC: RECORD:

Pt seen 8-11-05 - by clinical director full eval done. Pt refused cell-custody issues for outside trip pt-11-05

J. Barnes PA
Acting CMS/A

000178

U.S. Department of Justice
Federal Bureau of Prisons

Medical Treatment Refusal
(Rechazo de Tratamiento Médico)

Date (Fecha): 8/11/05

I, Baker, Daryl 19613-039 (Name and Registration Number) (Nombre y Número de Registro), refuse treatment recommended by the Federal Bureau of Prisons Medical staff for the following condition(s):
(rechaza el tratamiento recomendado por el Personal Médico del Bureau Federal de Prisiones, por las siguientes razones):

DESCRIBE IN LAYMAN'S TERMINOLOGY: (DESCRIBA EN TERMINOLOGIA COMUN Y CORRIENTE):

diplopia d/t old orbital entrapment

The following treatment(s) was/were recommended: (El siguiente tratamiento(s) fue/fueron recomendado(s)):

ophthalmology - routine evaluation

- I/M refused custody - cuffing for outside procedure

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento):

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions.

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehuso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por cause de respectar y seguir mis expresos deseos y direcciones.)

X Pt refuses to sign
X in stlt / cuffed - black box
Patient's Signature and Date (Firma del Paciente y Fecha)

I/M stld c/o pain - eye
"will not sign anything"

Michelle Kellerman 8/11/05.
Signature of Witness and Date (Firma del Testigo y Fecha)

8/11/05
Signature of Witness and Date (Firma del Testigo y Fecha)

Original - Inmate's Medical Record
Canary - Hospital File
Pink - To Inmate

000179

USP LVN

Previous editions not usable

BP-358(60)
MAY 1985

UNITED STATES GOVERNMENT

memorandum

FCI Elkton, Ohio

Date: 6/8/05

Reply to: Jane Barnes, PA-C
Attn of: Acting Assistant Health Services Administrator

Michele, Keller, D.O.
Clinical Director/URC Chairman

Subject: Community Referral Approval/Denial

To: Baker Darryl

Reg. No: 19613-039 Unit: G-A

This is to advise you that on 6/8/05, your medical case/condition was presented to the *Utilization Review Committee* to determine the clinical indication and/or benefit, as well as the urgency and non-urgency of referring you to the community to undergo additional diagnostic testing, and/or an evaluation by a specialist. It was the decision of the *Utilization Review Committee* that your case has been:

approved disapproved tabled at this time. (See below).

To the Cardiologist of the 2-3 months

If your case has been approved, you will be scheduled in the near future to have the diagnostic testing/surgical evaluation/specialists' evaluation, etc., performed in the community. Due to security concerns, you will not be advised of the date of the referral or be provided additional information on the Escorted Medical Trip until the date of the trip. If you have any change in your condition or symptoms, report them to the Clinical Director and/or your Primary Care Provider. ***If you decide that you do not agree with the referral and or testing, you MUST report to the Clinical Director (in writing) that you are not agreeing to proceed with the referral.

- If your case has been disapproved at this time, it has been determined by the committee that the benefit of the referral may not be achieved, and/or, your condition can be maintained in-house. This does not mean that you do not have a legitimate medical condition; however, it indicates that the condition may not be improved by a community referral or it is currently being managed and routinely evaluated in the Chronic Care Clinic. This does not mean that your condition may not warrant future referral to the community; however, this is based on results on continued in-house monitoring, diagnostic results and/or a change in your condition. If you have any questions, you must discuss this with the Clinical Director and/or your Primary Care Provider.

- If the decision to table your case was made, this indicates that you will be scheduled for an additional testing and/or evaluation and/or repeat evaluation in-house. Your case then will be presented to the Utilization Review Committee at a later date.

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) DOCTOR BEAM, M.D.	DATE: MARCH 28, 2004
FROM: INMATE BAKER, DARRYL	REGISTER NO.: 19613-039
WORK ASSIGNMENT: ORDERLY	UNIT: ~~AA~~ SHU AA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

DOCTOR BEAM, THIS IS A SICK CALL REQUEST IN REFERENCE TO A INJURY FROM AN ASSULT I RECEIVED TO MY EYE ON FEBRUARY 27, 2004. DOCTOR BEAM, MY EYE HAS NOT FULLY RECOVERED AND I NEED MEDICAL ATTENTION. DOCTOR BEAM, WOULD YOU PLEASE SET AN APPOINTMENT WHERE I CAN COME IN AND HAVE MY EYE EXAMINE.

THANK YOU.

(Do not write below this line)

DISPOSITION:

You were seen by Dr Howard 3/3/04
I will have you called on 4/1/04
for discussion of what needs
to be done

Signature Staff Member: BEAM, MD FCI MCKEAN Date: 3/31/04

000181

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) DOCTOR BEAM, M.D.	DATE: MARCH 28, 2004
FROM: INMATE BAKER DARRYL	REGISTER NO.: 19613-039
WORK ASSIGNMENT: ORDERLY	UNIT: A-SHU

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

DOCTOR BEAM, I HAVE BEEN REQUESTING MEDICAL ATTENTION TO BLEEDING AND PAIN TO THE SURFACE OF MY HEAD AND YOU GAVE ME MEDICATION THAT IS INEFFECTIVE. DOCTOR BEAM, I NEED SOME MEDICATION TO ALLIVIATE THIS PAIN I HAVE BEEN SUFFERING.

THANK YOU.

(Do not write below this line)

DISPOSITION:

I will call the medication

Signature Staff Member BEAM, MD SCI MCKEAN Date 3/31/04

000182

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

FEDERAL BUREAU OF PRISONS
memorandum

FCI McKean, Pennsylvania

DATE: March 23, 2004

REPLY TO ATTN. OF: James F. Sherman, Warden

SUBJECT: **INMATE REQUEST TO STAFF MEMBER**

TO: BAKER, Darryl
Reg. No. 19613-039

This is in response to your letter receipted in my office on March 12, 2004, in which you state that you suffered an eye injury on February 29, 2004 and have not received medical treatment for it.

Records indicate you were medically assessed immediately following the injury. You were instructed to follow up with sick call as needed following that assessment. A sick call slip was never received by health services from you; however, on March 9, 2004, at the request of the Associate Warden, a PA stopped by to examine you. You became verbally abusive and belligerent with the PA. You were given an order to stop your abusive behavior which you refused to do. The PA was not able to conduct an exam at that time due to your behavior. You were instructed of the proper way to sign up for sick call at that time. A sick call request was received from you on March 9, 2004, and you were seen by a doctor on March 11, 2004. The exam revealed a left eyelid abrasion only. No other injuries were found concerning your left eye.

I trust your concerns have been addressed.

LOU SENSITIVE

COPY

MCK41 535.03 * INMATE PROFILE * 03-12-2004
PAGE 001 OF 001 15:05:20

19613-039 REG
REGNO: 19613-039 FUNCTION: PRT DOB/AGE.: 06-30-1962 / 41
NAME.: BAKER, DARRYL ORRIN R/S/ETH.: B/M/O
RSP..: MCK-MCKEAN FCI MILEAGE.: 269 MILES
PHONE: 814-362-8900 FTS: 700-362-8909
PROJ REL METHOD: GOOD CONDUCT TIME RELEASE FBI NO..: 747008W1
PROJ REL DATE..: 07-02-2012 INS NO..: N/A
PAR ELIG DATE..: N/A SSN.....: 370782859
PAR HEAR DATE..: DETAINER: NO CMC..: YES
OFFN/CHG RMKS: DKT: 94-CR-50065-01-FL DIST. OF COCAINE BASE, A & A, P/W/I/T/D
OFFN/CHG RMKS: COCAINE BASE 235 MONTHS CUSTODY BOP

FACL	CATEGORY	- - - - -	CURRENT ASSIGNMENT - - - - - - -	EFF DATE	TIME
MCK	ADM-REL	A-DES	DESIGNATED, AT ASSIGNED FACIL	09-12-2002	0815
MCK	CARE LEVEL	CARE1	HEALTHY, NO CHRONIC CARE	06-10-2003	1449
MCK	COR COUNSL	AA	ELLEN MCNINCH - AA (EXT 547)	09-12-2002	0815
MCK	CASE MGT	PROG RPT	NEXT PROGRESS REPORT DUE DATE	07-05-2005	0757
MCK	CASE MGT	RPP NEEDS	RELEASE PREP PGM NEEDS	12-31-1996	1134
MCK	CASE MGT	V94 CDA913	V94 CURR DRG TRAF ON/AFT 91394	04-13-1996	1109
MCK	CASE MGT	V94 CVA913	V94 CURR VIOL ON/AFTER 91394	07-30-2001	1851
MCK	CORR SVCS	RAN NEG	RANDOM DRG TST-NEGATIVE	11-04-2003	1627
MCK	CASEWORKER	AA	CASEWORKER AA JEFF LABESKY	09-12-2002	0815
MCK	CUSTODY	IN	IN CUSTODY	10-04-1995	1205
MCK	DOCTOR	DR.B:00-48	DR.BEAM-FCI CASELOAD	09-16-2002	0837
MCK	DRUG PGMS	DRG I NONE	NO DRUG INTERVIEW REQUIRED	12-28-1995	1049
MCK	DRUG PGMS	NR DIS	NRES DRUG TMT/DISCONTINUED	09-06-2000	1012
MCK	EDUCATION	CDL	ACE - CDL	01-13-2004	1830
MCK	EDUC INFO	ESL HAS	ENGLISH PROFICIENT	11-16-1995	0922
MCK	EDUC INFO	GED HAS	COMPLETED GED OR HS DIPLOMA	11-14-1995	0850
MCK	FIN RESP	COMPLT	FINANC RESP-COMPLETED	10-09-1996	0849
MCK	LEVEL	MEDIUM	SECURITY CLASSIFICATION MEDIUM	08-25-2003	1028
MCK	MED DY ST	REG DUTY W	REGULAR DUTY W/MED RESTRICTION	09-12-2002	1511
MCK	PGM REVIEW	APR	APRIL PROGRAM REVIEW	04-30-2004	0755
MCK	QUARTERS	Z07-201UAD	HOUSE Z/RANGE 07/BED 201U AD	02-29-2004	0953
MCK	RELIGION	PROTESTANT	PROTESTANT	01-11-1996	1905
MCK	SECOND RSP	NOT USM	NOT RESPONSIBILITY OF USMS	09-12-2002	0815
MCK	UNIT	A	UNT MGR C. KINDERVATER 3597	09-12-2002	0815
MCK	WAITNG LST	CIM COMPLT	CIMS PKT COMPLETE	08-24-1998	0903
MCK	WAITNG LST	CMPTR D VT	COMPUTER VT WAIT LIST DAYS	03-01-2004	1544
MCK	WAITNG LST	DENTAL	MAIN DENTAL WAITING LIST	04-04-2003	1125
MCK	WAITNG LST	INDUSTRIES	UNICOR WLS	11-05-2002	1421
MCK	WAITNG LST	NON-SMOKER	NON-SMOKER	09-12-2002	2019
MCK	WRK DETAIL	SHU UNASSG	SHU UNASSIGNED	03-01-2004	0120

G0000 TRANSACTION SUCCESSFULLY COMPLETED

From: 04 MAR 15 AM 8:34 Warden's Office		Control Number: 2004-021
Subject: Baker, Darryl # 19613-039	Date Received: 3/12/04	Date Due: 3/19/04

Remarks:

✓ Please prepare a written response for the Warden's signature by 3/19/04.

____ Please respond under your signature.

____ File for your information.

____ Initial & forward.

____ If you are unable to meet the deadline, please contact the Warden's Secretary to request an extension.

To:

✓ AW(O)
____ AW(P)
____ SOI
____ Camp Administrator
____ Executive Assistant
____ Captain
____ Case Management Coordinator
____ Chaplain
____ Chief Psychologist
____ Chief Medical Officer
____ Computer Services Manager
____ Controller
____ Employee Development Mgr.
____ Facility Manager
____ Food Service Administrator
✓ Health Services Administrator
____ Human Resource Manager
____ Inmate Systems Manager
____ Recreation Supervisor
____ Safety Manager
____ Supervisor of Education
____ UNICOR Factory Manager
____ Unit A Manager
____ Unit B Manager
____ Unit C Manager
____ Unit D Manager
____ Other: ________

HSA Prepare a response for my signature. Guy please track and advise. Thks. JF

BP-S148.055 INMATE REQUEST TO STAFF CDFRM
SEP 98

Dr Beam

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) DR. BEAM M.D.	DATE:
FROM: INMATE BAKER	REGISTER NO.: 16917-039
WORK ASSIGNMENT:	UNIT:

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

My MEDICINE IS ALL GONE AND THE BUMPS ARE RETURNING. I NEED SOME CYTOXAN MEDICINE

THANK YOU.

(Do not write below this line)

DISPOSITION:

Please bring this up with the MLP on Stockcall

Signature Staff Member H. BEAM, MD FCI MCKEAN Date 3/24/04

000186

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94